U.S. Department of Labor

Office of Administrative Law Judges
Seven Parkway Center - Room 290
Pittsburgh, PA 15220

(412) 644-5754
(412) 644-5005 (FAX)

Issue Date: 16 April 2003

CASE NO.: 2002-BLA-244

In the Matter of:

ROBERT J. DAMRON
Claimant

v.

WESTMORELAND COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances:

Roger D. Forman, Esquire
For the Claimant

Kathy Snyder, Esquire
For the Employer

Before: MICHAEL P. LESNIAK
Administrative Law Judge

DECISION AND ORDER – AWARDING BENEFITS

This case arises from a claim for benefits under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 et seq. (hereinafter referred to as "the Act"), and applicable federal regulations, mainly 20 C.F.R. Parts 410, 718 and 727 ("Regulations").

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as black lung.[1]

A formal hearing was conducted in Beckley, West Virginia on October 9, 2002, at which time all parties were afforded a full opportunity to present evidence and argument, as provided in the Act and Regulations issued thereunder, found in Title 20, Code of Federal Regulations.[2] The record was left open for the submission of additional medical evidence. The parties filed a "Stipulation of Objective Evidence" on December 4, 2002. Claimant filed his closing argument on December 30, 2002. Employer filed its closing brief on December 19, 2002.

ISSUES

The contested issues are:

1. Whether Claimant has pneumoconiosis;
2. Whether the pneumoconiosis arose out of Claimant's coal mine employment;
3. Whether Claimant is totally disabled;
4. Whether the total disability was due to pneumoconiosis; and
5. Whether Claimant has established a change of condition or a mistake in determination of fact pursuant to § 725.310. (TR 17-18).

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[1] The following abbreviations have been used in this opinion: DX = Director's exhibit, EX = Employer's exhibit, CX = Claimant's exhibit, TR = Transcript of the hearing, BCR = Board-certified radiologist, BCI = Board-certified internist, and B = B reader.

[2] At the hearing Director's Exhibits 1-101 and Claimant's Exhibits 1-2 and 4 were admitted into evidence. (TR 5, 7, 9).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History and Factual Background[3]

Claimant filed his claim for benefits on March 25, 1993. This claim was subsequently denied by the district director on September 2, 1993. (DX 16). The case was referred to the Office of Administrative Law Judges ("OALJ"). On January 9, 1995, Administrative Law Judge ("ALJ") Richard Huddleston issued a Decision and Order Denying Benefits. Judge Huddleston found that Claimant failed to establish both the existence of pneumoconiosis and the presence of a totally disabling respiratory impairment. (DX 45). Claimant appealed the decision to the Benefits Review Board ("BRB") and at the same time filed a request for modification. (DX 48). On May 26, 1995, the BRB dismissed the appeal and remanded the case for consideration of Claimant's request for modification. (DX 49). On April 17, 1997, Judge Huddleston issued a Decision and Order Denying Modification after again concluding the evidence was insufficient to establish both the existence of pneumoconiosis and a totally disabling respiratory impairment. (DX 63). Claimant appealed the denial of benefits to the BRB but at the same time requested modification. (DX 65). The BRB dismissed the appeal and remanded the case for consideration of the request for modification. (DX 71). On March 30, 1999, ALJ Daniel L. Leland issued a Decision and Order Denying Benefits. In his decision, Judge Leland found Claimant had demonstrated a mistake in a prior determination of fact inasmuch as the evidence established the presence of a totally disabling respiratory impairment pursuant to § 718.204(c). However, he also found Claimant failed to establish the existence of pneumoconiosis pursuant to § 718.202(a)(1)-(4). (DX 89). Claimant appealed this decision and requested the BRB reinstate the two previous appeals. The BRB granted Claimant's request and reinstated the appeals. On April 19, 2000, the BRB issued a Decision and Order affirming the denial of benefits. (DX 96). On March 21, 2000, Claimant, for the third time, requested modification of the denial of benefits. (DX 97). On August 8, 2000, the district director referred this claim to the OALJ for further consideration. (DX 100).

A hearing was held on October 9, 2002 in Beckley, West Virginia. At that time Director's exhibits 1 through 101 and Claimant's exhibits 1 and 2 were admitted into evidence without objection. (TR 5, 7). Employer objected to Claimant's exhibit 3, that contained x-ray reports from 1973, 1999, 2000, and 2001, on the basis that they were in existence but not in evidence before the district director in violation of § 725.456(d). I

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[3] Given the filing date of this claim, subsequent to the effective date of the permanent criteria of Part 718, (i.e. March 31, 1980), the regulations set forth at 20 C.F.R. Part 718 will govern its adjudication. Because the miner's last exposure to coal mine dust occurred in West Virginia, this claim arises within the territorial jurisdiction of the United States Court of Appeals for the Fourth Circuit. *See Broyles v. Director, OWCP*, 143 F.3d 1348, 21 BLR 2-369 (10th Cir. 1998).

reserved ruling on the admission of Claimant's exhibit 3 allowing Claimant an opportunity to provide an explanation, post-hearing, why these exhibits were not previously submitted. (TR 10). By letter of October 10, 2002, counsel for Claimant agreed that the 1973 x-ray report of Dr. Pelaez should be excluded but argued that the other items, while in existence, were in hospital records "which were received and then reviewed and submitted at the time we received them, not before." Counsel added that he did not believe that the law required "us to wantonly spend our client's money to seek every available record."

Section 725.456(d) mandates the exclusion of withheld evidence in the absence of extraordinary circumstances. *Wilkes v. F&R Coal Co.*, 12 BLR 1-1 (1988). Although the explanation provided by counsel for Claimant was not entirely clear, I infer from his letter that the x-ray reports at issue were contained within hospital medical records that were just recently received and reviewed by counsel and that counsel submitted the x-ray readings as soon as he was aware of them. Employer has not submitted any evidence to the contrary.[4] Therefore, I accept Claimant's position and find that counsel for Claimant submitted the x-ray evidence as soon as he was aware of it and that the reports were not intentionally withheld as evidence. Accordingly, as extraordinary circumstances have been demonstrated, Employer's objection to Claimant's exhibit 3 is overruled and, with the exception of the 1973 x-ray reading of Dr. Pelaez, is admitted into evidence.

Employer also objected to Claimant's exhibit 4, consisting of a medical report and 16 x-ray readings, because it was submitted in violation of the 20-day rule pursuant to § 725.456(b) and because Claimant failed to update the answers to his interrogatories regarding the new evidence. At the hearing, I decided to admit the exhibit but allowed Employer 30 days to submit rebuttal evidence. (TR 8-9).

Claimant then objected to the admission of Employer's exhibits 1 through 10 on the basis they were cumulative and were not probative. I noted Employer's exhibits 5 through 10 were exchanged with Claimant on the day of the hearing but that they were in response to the late filing of Claimant's exhibit 4. I decided to reserve ruling on the admission of Employer's exhibits 1 through 10 until I could review all of Employer's exhibits to determine whether any, some, or all were cumulative. (TR 14). By letter of October 10, 2002, counsel for Claimant withdrew his objection to Employer's exhibits 1 through 4 but renewed his objection to Employer's exhibits 5 through 10 on the basis they

[4] Employer had an opportunity, through the discovery process, to discover the x-ray reports since they were contained within hospital medical records that were not under the direct control of Claimant.

were not probative but were duplicative and cumulative.[5] Moreover, counsel objected on the basis that the supplemental reports violated the 20-day rule to the extent that each report contained a review of additional evidence (outside of Claimant's exhibit 4) that exceeded rebuttal. Employer filed a Response to Claimant's Objections on October 21, 2002 arguing that the supplemental reports marked as Exhibits 5 through 10 were not cumulative. Moreover, Employer argued that it had 30 days to respond to Claimant's late evidence as required by § 725.456(b)(3). I agree that Employer has a right to rebuttal and "to take such action as each considers appropriate *in response to such evidence*." § 725.456(b)(3). However, although it is up to Employer to decide by what method it will respond, it is clear that the scope of the rebuttal is limited to a review of the evidence that was submitted in violation of the 20-day rule. In this case, Employer decided to respond by submitting six supplemental reports. Accordingly, I find to the extent that the supplemental reports exceed the scope of that evidence submitted in violation of the 20-day rule, those portions will be stricken from the evidence. Employer cannot use the chance for rebuttal as an opportunity to circumvent the 20-day rule in an effort to introduce additional medical opinion on evidence previously submitted. Additionally, I find that any further comment by these physicians regarding evidence previously submitted in accordance with the 20-day rule would also be unduly repetitious and should be stricken on these grounds as well. Accordingly, Employer's exhibits 1 through 10 are admitted into evidence subject to the noted exclusions.

Post-hearing, Employer submitted exhibits 11 through 19 as additional rebuttal evidence to Claimant's exhibit 4. On November 13, 2002, Claimant filed objections to Employer's exhibits 17, 18, and 19 on the grounds that "they are not responsive but employer has had enough response and they are duplicative and non-probative cumulative evidence."[6] On November 20, 2002, Employer filed its response to Claimant's objections, arguing that the offered assessments were from various experts with different qualifications, backgrounds, and experience. Employer maintained that said exhibits were probative evidence and were not cumulative. I agree. Pursuant to § 725.456(b)(3), Employer is entitled to submit evidence in response to the evidence submitted in violation of the 20-day rule. I find that each physician has analyzed the medical evidence, in this case chest x-rays, and has given a unique and probative analysis. Accordingly, Claimant's objection is overruled and Employer's exhibits 11 through 19 are admitted into evidence.

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[5] These exhibits are as follows: EX 5 = supplemental report of Dr. Spagnolo; EX 6 = supplemental report of Dr. Chillag; EX 7 = supplemental report of Dr. Castle; EX 8 = supplemental report of Dr. Rosenberg; EX 9 = report of Dr. Fino; and EX 10 = supplemental report of Dr. Louden.

[6] Employer's exhibit 17 is comprised of interpretations by Dr. Wiot of x-rays dated April 12, 1999, March 7, 2000, May 18, 2001; Employer's exhibit 18 is comprised of interpretations by Dr. Spitz of x-rays dated April 12, 1999, March 7, 2000, May 18, 2001; and Employer's exhibit 19 is the curriculum vitae of Dr. Spitz.

Claimant testified at the hearing that he was unable to do much of anything and that he had trouble getting enough air. (TR 19). He noted that he stopped smoking cigarettes twenty-six years ago. (TR 20). He testified that his last coal mine job was as Manager of Health and Safety for a coal mine. (TR 20). His job included walking and crawling when he was inspecting the job site. (TR 20-21). He also did some paper work at his desk as part of his job. (TR 20). He felt he was unable to perform his last coal mine job because of the walking and crawling needed to perform inspections. (TR 21). Claimant was 73 years old at the hearing. (TR 20). Claimant stated he stopped smoking in the 1970s but that he smoked from the age of 16 or 18 or approximately from 1945 up to the 1970s. (TR 22).

Medical Evidence

The excellent summaries of the medical evidence by Judge Huddleston in his Decision and Orders of January 9, 1995 and April 11, 1997 and those by Judge Leland in his Decision and Order of March 30, 1999 are incorporated by reference. This opinion only summarizes the evidence submitted since Claimant filed his most recent request for modification.

Chest x-rays[7]

X-ray	Reading	Exhibit	Physician	Interpretation
4/12/99	4/12/99	CX 3	Gogineni BCR,B	Interstitial reticular nodular type disease upper lungs, more rt.

[7] A-A-reader; B-B-reader; BCR-Board-Certified Radiologist; R-Radiologist; BCP-Board-Certified Pulmonologist; BCI Board-Certified Internal Medicine; BCCC-Board-Certified Critical Care. Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. B-readers need not be radiologists. The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b).

X-ray	Reading	Exhibit	Physician	Interpretation
4/12/99	9/5/02	CX 4	Pathak B	1/2, p/q, Cat.A;ax;em; id;kl;pi
4/12/99	9/16/02	CX 4	Miller B	1/2, q/t, Cat O;ax;em; kl;pi
4/12/99	9/10/99	CX 4	Cappiello BCR,B	1/2, p/q, Cat. O;ax;em
4/12/99	9/11/02	CX 4	Ahmed BCR,B	2/1, q/p, Cat.A;ax;bu; em;id;ih;kl;pi
4/12/99	9/17/02	EX 4	Wheeler BCR,B	Negative;OD;em;pi;tb comments
4/12/99	9/17/02	EX 4	Scott BCR,B	Negative;em;tb; comments
4/12/99	9/17/02	EX 4	Scatarige BCR,B	Negative; OD;em;tb; comments
4/12/99	10/7/02	EX 5	Fino B	Negative;comments
4/12/99	10/19/02	EX 17	Wiot BCR,B	0/0; em; active tb
4/12/99	10/29/02	EX 18	Spitz BCR,B	0/0; di;em; granulomateous dis.
4/12/99	10/29/02	EX 15	Meyer BCR,B	0/0;tb;irregular air-space opacity in both apices sl. Nodular on left;em; possible IPF/ UIP
3/7/00	3/7/00	CX 3	Gogineni BCR,B	COPD;reticulo-nodular interstitial disease; bibasilar fib.

X-ray	Reading	Exhibit	Physician	Interpretation
3/7/00	9/5/02	CX 4	Pathak B	1/2, p/q; Cat.A; ax;em id;kl;pi
3/7/00	9/16/02	CX 4	Miller B	1/2, q/t; Cat.O; ax;em; pi
3/7/00	9/10/02	CX 4	Cappiello BCR,B	1/2, p/q;Cat.A; ax;em
3/7/00	9/11/02	CX 4	Ahmed BCR,B	2/1, q/p;Cat.A; ax;bu; em;id;ih;kl;pi
3/7/00	9/17/02	EX 4	Wheeler BCR,B	Negative;OD;em;tb; comments
3/7/00	9/17/02	EX 4	Scott BCR,B	Negative;OD; em;tb; comments
3/7/00	9/17/02	EX 4	Scartarige BCR,B	Negative;OD; em;tb; comments
3/7/00	10/7/02	EX 5	Fino B	Negative; comments
3/7/00	10/19/02	EX 17	Wiot BCR,B	0/0; em; RUL strand
3/7/00	10/26/02	EX 18	Spitz, BCR,B	0/0;di;em; granulo-mateous
3/7/00	10/29/02	EX 15	Meyer BCR,B	0/0;kl; improving left upper lung opacity; suggests resolving inflammatory process; rare basilar linear opacities suggest IPF; em
5/18/01	5/18/01	CX 3	Maloof BCR	COPD w/pulmonary fibrosis in upper lobes bilaterally

X-ray	Reading	Exhibit	Physician	Interpretation
5/18/01	9/5/02	CX 4	Pathak B	1/2, p/q; Cat.A;ax;em; id;kl;pi
5/18/01	9/16/02	CX 4	Miller B	1/2, q/t; Cat.O;ax;em; pi
5/18/01	9/10/02	CX 4	Cappiello BCR,B	1/2, p/q; Cat.A;ax;em; id
5/18/01	9/11/02	CX 4	Ahmed BCR,B	2/1, q/p; Cat.A;ax;bu; em;id;ih;kl;pi
5/18/01	9/17/02	EX 4	Wheeler BCR,B	Negative;OD;em;tb; comments
5/18/01	9/17/02	EX 4	Scott BCR,B	Negative;OD;em;tb; comments
5/18/01	9/17/02	EX 4	Scatarige BCR,B	Negative:OD;em;tb; comments
5/18/01	10/7/02	EX 5	Fino B	Negative; comments
5/18/01	10/19/02	EX 17	Wiot BCR,B	0/0;em; stranding RUL;bronchiectasis
5/18/01	10/29/02	EX 18	Spitz BCR,B	0/0;em;di; granulo-mateous disease
5/18/01	10/29/02	EX 15	Meyer BCR,B	0/0;em;focal right apical scarring w/ pleural thickening & bronchiectasis;rare opacities at both bases due to fibrosis of IPF

X-ray	Reading	Exhibit	Physician	Interpretation
6/18/02	6/18/02	CX 1	Hayes, BCR,B[8] Walker Henry, BCI	parenchymal changes consistent with CWP
6/18/02	9/5/02	CX 4	Pathak B	1/2, p/q;Cat.A;ax;em; id;kl;pi
6/18/02	9/16/02	CX 4	Miller BCR,B	2/1, t/q;Cat.O;ax;em; id;pi
6/18/02	9/10/02	CX 4	Cappiello BCR,B	2/1, p/q;Cat.A;ax;em; id
6/18/02	9/11/02	CX 4	Ahmed BCR,B	2/1, q/p;Cat.A;ax;bu; em;id;ih;kl;pi
6/18/02	10/15/02	EX 11	Scott BCR,B	0/0;em;minimal linear fibrosis apices compatible w/healed tb; probable calcified granuloma rt CP angle; minimal fibro-sis infiltrate or atelectasis lt base
6/18/02	10/15/02	EX 12	Scatarige BCR,B	0/0;tb;em;ill-defined opacities both upper lobes due to tb of unknown origin;small calcified granulomata RLL; scarring LLL

[8] This x-ray was taken in conjunction with a determination by the Occupational Pneumoconiosis Board. It is unclear which of the three physicians on the Board read the chest x-ray.

X-ray	Reading	Exhibit	Physician	Interpretation
6/18/02	10/16/02	EX 13	Wheeler BCR,B	0/0;moderate em; min linear fibrosis compatible w/tb unknown activity; probably healed min linear fibrosis in left base & few nodules compatible w/granulomata in right CPA
6/18/02	10/30/02	EX 14	Wiot BCR,B	0/0;em;change RUL consistent w/old tb; bronchiectasis
6/18/02	10/30/02	EX 15	Meyer BCR,B	0/0;em;tb;biapical opacities; pleural thickening consistent w/post-infectious/inflammatory change; focal opacity at left base suggests focal scarring

Pulmonary Function Studies

Date	Exhibit	Physician	HT.	Age	FEV1	FVC	MVV	FEV1/ FVC
6/18/02	CX 1	O.P. Board	64.5	72	1.23	2.97	47	41%

Medical Reports

Dr. Robert Cohen

The medical report of Dr. Cohen is dated February 20, 2001 and appears at DX 97. Dr. Cohen is Board Certified in Internal Medicine, Pulmonary Disease, and Critical Care Medicine and is also a B-reader of chest x-rays. (DX 97). Dr. Cohen reviewed Claimant's employment history and noted 43 years of coal mine employment. He noted a smoking history of 24 to 25 pack years ending in 1977. Dr. Cohen conducted a comprehensive review of the medical evidence in this case including a review of the medical reports, chest x-ray reports, CT Scan reports, pulmonary function testing, arterial

blood gases, cardiopulmonary exercise testing, and the deposition testimony of Drs. Crisalli and Castle. Dr. Cohen opined that Claimant had pneumoconiosis based on the following: (1) Claimant's history of 43 years of coal mine employment in underground mines; (2) Claimant's symptoms of chronic lung disease for at least 8 years prior to his first DOL exam in 1993 and that he had symptoms of gradually progressive shortness of breath, cough, sputum production, and wheezing; (3) pulmonary function testing that showed moderate obstructive lung disease with some reversibility. However, he disagreed with others who diagnosed the presence of asthma. He added that lung volume studies were consistent with emphysema. Dr. Cohen opined that the cause of the obstructive impairment was Claimant's 25 pack year smoking history and his 43 years of coal mine dust exposure; (4) arterial blood gases were essentially normal; (5) significant and substantial x-ray evidence of simple pneumoconiosis with some readers diagnosing complicated pneumoconiosis. Dr. Cohen noted that there was no clinical record of Claimant having had a granulomatous infection. Moreover, Dr. Cohen noted that even if the chest x-ray evidence were negative, it would not change his opinion that Claimant "has clear clinical and physiologic evidence of moderate obstructive lung disease, diffusion impairment, and gas exchange abnormalities with exercise" which were caused by his more than 43 years of exposure to coal mine dust and 25 pack year smoking history; and (6) no history of any other occupational exposure which could cause CWP, obstructive lung disease, diffusion impairment, or gas exchange abnormalities with exercise. Dr. Cohen opined Claimant had two significant exposures that contributed significantly to these physiologic abnormalities: 43 years of coal mine dust exposure and his modest exposure to tobacco smoke. Moreover, Dr. Cohen opined Claimant's combined respiratory impairment, moderate obstruction, diffusion impairment, and altered gas exchange with exercise, would disable Claimant from his last coal mine job as a health and safety inspector. Dr. Cohen then dedicated a significant portion of his report to a discussion regarding the relationship between obstructive lung disease and coal dust. He also specifically responded to the opinions of Drs. Loudon, Castle, and Fino. Lastly, Dr. Cohen discussed Claimant's response to bronchodilators and its relationship to coal mine dust. He concluded that Claimant had a response to bronchodilators but at no time did he reverse beyond a moderate obstructive impairment. He added this response to bronchodilators was quite consistent with exposure to coal mine dust and was not uncommon. In conclusion, Dr. Cohen opined that coal mine dust exposure and tobacco smoke exposure contributed significantly to Claimant's moderate obstructive lung disease, diffusion impairment, gas exchange abnormality, and emphysema noted on chest x-ray and CT Scan. He added that this degree of impairment was disabling for his last coal mine job as a health and safety inspector.

The supplemental report of Dr. Cohen is dated September 19, 2002 and appears at CX 4. He reviewed the supplemental record reviews provided by Drs. Chillag, Loudon, Fino, Castle, Spagnolo, Rosenberg, and Crisalli. Dr. Cohen acknowledged Dr. Spagnolo's criticism that in his initial report he did not make a clear determination of the presence or absence of pneumoconiosis from the chest x-ray reports. Dr. Cohen explained that

because he did not personally review the x-rays, he found the dataset to be mixed making it difficult to come to a firm conclusion in this regard. He added that he could not place the same confidence as Dr. Spagnolo in the readings of Drs. Wheeler, Wiot, Spitz, Shipley, and Fishman since he has, in the past, had the opportunity to review x-rays also reviewed by said group and has disagreed strongly with their interpretations. Dr. Cohen's conclusions remained unchanged from his previous opinion.

Dr. Shawn A. Chillag

The medical report of Dr. Chillag is dated July 9, 2001 and appears at DX 98. Dr. Chillag is Board Certified in Internal Medicine. (DX 98). Dr. Chillag noted he reviewed the provided file on Claimant. In addition, he reviewed previous letters submitted by him on May 16, 1994, July 5, 1994, April 29, 1998, and December 29, 1998. He noted that all of the foregoing letters offered the opinion that Claimant did not have pneumoconiosis or disability related to pneumoconiosis. He added that Claimant had some pulmonary impairment secondary to his history of cigarette smoking. Dr. Chillag concluded he saw no reason to change his opinions and stated: (1) there was no sufficient objective evidence to justify a diagnosis of coal worker's pneumoconiosis ("CWP"); (2) Claimant did have a pulmonary impairment attributable to cigarette smoking and reactive airways disease (asthma) that could be related to smoking and/or a condition of the population at large; (3) Claimant was unable to perform his last coal mine duties due to old age and some pulmonary impairment which contributed; (4) Claimant's disability was not caused in whole or in part from pneumoconiosis or occupational lung disease; and (5) the degree and/or cause of any pulmonary impairment or disability would not change if Claimant were found to have simple pneumoconiosis.

The supplemental report of Dr. Chillag is dated October 2, 2002 and appears at EX 6. Dr. Chillag was provided additional material to review including the recent reports of Drs. Rosenberg (May 14, 2002), Crisalli (May 20, 2002), and Spagnolo (May 26, 2002), the decision of the Occupational Pneumoconiosis Board, several chest x-ray reports (CX 3), and the supplemental report of Dr. Cohen (September 19, 2002).[9] None

[9] As noted earlier, this report was admitted as rebuttal evidence to the late filing of Claimant's exhibit 4 that contained the September 19, 2002 supplemental report of Dr. Cohen and x-ray readings from March 7, 2000, April 12, 1999, and May 18, 2001. Those portions of this opinion that are not directly responsive to Claimant's exhibit 4 exceed the scope of rebuttal and are excluded from evidence. Employer cannot use the chance for rebuttal as an opportunity to circumvent the 20-day rule in an effort to introduce additional medical opinion on evidence previously submitted in compliance with the 20-day rule. Moreover, any reference to evidence previously submitted in compliance with the 20-day rule is unduly repetitious and should be excluded on that basis as well.

of the relevant additional information provided grounds for Dr. Chillag to change his previous opinions.

Dr. Robert G. Loudon

The medical report of Dr. Loudon is dated July 24, 2001 and appears at DX 98. Dr.Loudon does not appear to have any board certifications but was educated in Great Britain and has been published widely in the area of pulmonary disease. (DX 98). Dr. Loudon reviewed and summarized, in addition to his own reports, the medical reports of Drs. Chillag, Castle, Fino, and Cohen. He opined that the evidence supporting a causal relationship between cigarette smoking and the development of chronic obstructive pulmonary disease ("COPD") was strong, and the relationship was strong. Moreover, he added that the evidence supporting a causal relationship between coal mine dust exposure and the development of COPD was much weaker and the relationship was much weaker. He concluded that there was no reason to change his previous opinions in this matter. He concluded: (1) there was not sufficient objective evidence to justify a diagnosis of CWP in Claimant; (2) Claimant had a respiratory impairment resulting from airflow obstruction caused by cigarette smoking and an asthmatic tendency. He added that this response to bronchodilators and appropriate treatment would "probably" reduce the impairment, now variable, from moderate to mild in degree; (3) Claimant was "probably not totally and permanently disabled to the extent that he is unable to do his regular coal mining work" for reasons stated in #2; and (4) his opinion regarding the degree or cause of respiratory impairment or disability would not change if Claimant were found to have CWP.

The supplemental report of Dr. Loudon is dated October 5, 2002 and appears at EX 10. Dr. Loudon reviewed and summarized the medical reports of Drs. Rosenberg (May 14, 2002), Crisalli (May 20, 2002), Spagnolo (May 26, 2002), and Cohen (September 19, 2002), pulmonary function test results from June 18, 2002, additional x-ray interpretations, and the Occupational Pneumoconiosis Board findings.[10] After reviewing Dr. Cohen's supplemental report and additional x-ray interpretations, Dr. Loudon concluded, "I see no reason to change …. the other opinions which I presented in my report of July 24, 2001…"

[10] As noted earlier, this report was admitted as rebuttal evidence to the late filing of Claimant's exhibit 4 that contained the September 19, 2002 supplemental report of Dr. Cohen and x-ray readings from March 7, 2000, April 12, 1999, and May 18, 2001. Those portions of this opinion that are not directly responsive to Claimant's exhibit 4 exceed the scope of rebuttal and are excluded from evidence. Employer cannot use the chance for rebuttal as an opportunity to circumvent the 20-day rule in an effort to introduce additional medical opinion on evidence previously submitted in compliance with the 20-day rule. Moreover, any reference to evidence previously submitted in compliance with the 20-day rule is unduly repetitious and should be excluded on that basis as well.

Dr. Gregory Fino

The medical report of Dr. Fino is dated July 26, 2001 and appears at DX 99. Dr. Fino is Board-Certified in Internal Medicine and Pulmonary Disease and is a certified B-reader of chest x-rays. (DX 99). Dr. Fino previously filed reports on July 21, 1994, October 26, 1998, and January 4, 1999. It was his opinion that Claimant had asthma and a smoking-related obstructive ventilatory abnormality. Moreover, he opined Claimant was disabled from performing his last mining job or a job requiring similar effort. Dr. Fino reviewed additional evidence including the medical reports of Drs. Chillag, Castle, Loudon, and Cohen. He summarized the pulmonary function tests, arterial blood gases, chest x-ray reports, and smoking and occupational histories. Dr. Fino concluded this additional information did not cause him to change any of his opinions as expressed in his last report.

The supplemental report of Dr. Fino is dated October 7, 2002 and appears at EX 9. Dr. Fino reviewed all of the chest x-ray interpretations of the May 9, 1973, April 12, 1999, March 7, 2000, and May 18, 2001 x-rays, the medical reports of Drs. Rosenberg (May 14, 2002), Crisalli (May 20, 2002), Spagnolo (May 26, 2002), and the supplemental report of Dr. Cohen (September 19, 2002), and the Occupational Pneumoconiosis Board Findings. Dr. Fino concluded the additional chest x-rays from April 12, 1999, March 7, 2000, and May 18, 2001 did not show simple or complicated CWP and he classified them as 0/0. He did note granulomatous changes in the upper zones consistent with old tuberculosis or a fungal infection. Dr. Fino concluded the additional medical information and chest x-rays did not cause him to change any of his opinions.

Dr. James R. Castle

The medical report of Dr. Castle is dated July 26, 2001 and appears at DX 99. Dr. Castle is Board-Certified in Internal Medicine and Pulmonary Disease and is a certified reader of chest x-rays. (DX 99). Dr. Castle reviewed his medical reports from May 26, 1998, January 4, 1999, and a deposition transcript from January 5, 1999. He also reviewed the reports of Drs. Fino, Loudon, and Cohen. Dr. Castle concluded that a review of the additional medical evidence had not altered any of his previously stated opinions. He added that the additional evidence continued to confirm Claimant had evidence of a partially reversible moderate airway obstruction without restriction of significant diffusion abnormality. It continued to be his opinion that Claimant did not have a permanently and totally disabling dust disease of the lungs that had been caused by, contributed to, or substantially aggravated by coal mine dust exposure. Dr. Castle concluded Claimant "probably" was permanently and totally disabled as a result of tobacco- smoke- induced COPD and bronchial asthma.

The supplemental report of Dr. Castle is dated October 7, 2002 and appears at EX 7. Dr. Castle reviewed the medical reports of Drs. Rosenberg (May 14, 2002), Crisalli

(May 20, 2002), Spagnolo (May 26, 2002), the supplemental report of Dr. Cohen (September 19, 2002), and the Occupational Pneumoconiosis Board Findings. In addition, Dr. Castle reviewed various interpretations of the May 18, 2001, March 7, 2000, April 12, 1999, and June 18, 2002 chest x-rays.[11] Dr. Castle stated it continued to be his opinion that there was insufficient evidence to justify a diagnosis of CWP and that it remained his opinion Claimant was permanently and totally disabled as a result of tobacco-smoke-induced COPD and bronchial asthma.

Dr. David M. Rosenberg

The medical report of Dr. Rosenberg is dated May 14, 2002 and appears at EX 2. Dr. Rosenberg is Board-Certified in Internal Medicine, Pulmonary Disease, and Occupational Medicine and is a certified B-reader of chest x-rays. (EX 2). Dr. Rosenberg conducted a thorough review and summary of the medical evidence. Dr. Rosenberg concluded that considering the B-readings of the chest x-rays and CAT scan evidence it was clear Claimant's roetenographic changes represented an inflammatory process in the upper fields of a previous granulomatous infection. He concluded Claimant did not suffer from the interstitial form of CWP. He added, from a functional perspective, Claimant had obstructive lung disease. Dr. Rosenberg noted the airflow obstruction was associated with a bronchodilator response, although afterwards, Claimant was still left with significant airflow obstruction. He stated that "probably based on the decreased FEV 1% ratios" Claimant would be disabled from performing his last coal mine employment. He noted this impairment and disability was related to the presence of COPD, not the interstitial form of CWP. Dr. Rosenberg acknowledged coal mine dust exposure could cause the development of COPD. He also noted this COPD would occur irrespective of whether the chest x-ray was considered negative for CWP. Dr. Rosenberg then stated, "The question is, can disabling chronic obstructive pulmonary disease occur in the setting of either a negative chest x-ray or with roentgenographic evidence absent complicated CWP." After discussing several studies, Dr. Rosenberg concluded that while coal dust exposure could cause COPD, in contrast to what was reported by Dr. Cohen, there was no evidence that severe disabling COPD occurred in relationship to coal mine dust, absent the presence of complicated CWP. Dr. Rosenberg opined Claimant did not have complicated CWP and that even if Claimant had a degree of simple CWP he would not

[11] As noted earlier, this report was admitted as rebuttal evidence to the late filing of Claimant's exhibit 4 that contained the September 19, 2002 supplemental report of Dr. Cohen and x-ray readings from March 7, 2000, April 12, 1999, and May 18, 2001. Those portions of this opinion that are not directly responsive to Claimant's exhibit 4 exceed the scope of rebuttal and are excluded from evidence. Employer cannot use the chance for rebuttal as an opportunity to circumvent the 20-day rule in an effort to introduce additional medical opinion on evidence previously submitted in compliance with the 20-day rule. Moreover, any reference to evidence previously submitted in compliance with the 20-day rule is unduly repetitious and should be excluded on that basis as well.

have developed disabling COPD. Dr. Rosenberg concluded that Claimant did not have CWP and that while he did have a disabling COPD, this pulmonary condition and resultant impairment was not caused or hastened by his past coal mine employment. He opined this obstructive lung disease was etiologically related to Claimant's past smoking history. Dr. Rosenberg added that with respect to the degree and cause of impairment, his opinion would not change if Claimant were found to have a degree of CWP.

The supplemental report of Dr. Rosenberg is dated October 8, 2002 and appears at EX 8. Dr. Rosenberg reviewed the medical reports of Drs. Crisalli (May 20, 2002), Spagnolo (May 26, 2002), the supplemental report of Dr. Cohen (September 19, 2002), and the Occupational Pneumoconiosis Board Findings. In addition, Dr. Rosenberg reviewed various interpretations of the May 9, 1973, May 18, 2001, March 7, 2000, April 12, 1999, and June 18, 2002 chest x-rays.[12] Again Dr. Rosenberg stated coal mine dust exposure could cause COPD. He stated, "The issue to be discussed, specifically, is whether or not Mr. Damron's disabling COPD is related to or has been exacerbated by coal mine dust exposure, or is it simply consequent to his smoking consumption." Dr. Rosenberg noted FEV-1 % was the parameter used to define COPD and stated that the FEV-1 % did not decrease in relationship to coal mine dust exposure or years of employment in the mines. Thus, "while Dr. Cohen sites various studies which describe declines in FEV-1 (not FEV-1 %) among coal miners, they do not causally relate Mr. Damron's COPD (and decreased FEV-1 %) to past coal mine dust exposure." He concluded that the additional medical information did not change his prior opinion.

Dr. Robert J. Crisalli

The medical report of Dr. Crisalli is dated May 20, 2002 and appears at EX 1. Dr. Crisalli is Board-Certified in Internal Medicine and Pulmonary Disease. (EX 1). Dr. Crisalli reviewed his previously submitted medical reports dated May 2, 1994, July 13, 1994, a deposition transcript September 1, 1994, June 18, 1996, and October 1, 1998. He also reviewed the medical reports of Drs. Fino, Chillag, Castle, Loudon, and Cohen. Dr. Crisalli concluded there was not sufficient evidence to justify a diagnosis of CWP or any chronic dust disease of the lung caused by, significantly related to, or substantially aggravated by coal mine employment in this case. He noted that Claimant had

[12] As noted earlier, this report was admitted as rebuttal evidence to the late filing of Claimant's exhibit 4 that contained the September 19, 2002 supplemental report of Dr. Cohen and x-ray readings from March 7, 2000, April 12, 1999, and May 18, 2001. Those portions of this opinion that are not directly responsive to Claimant's exhibit 4 exceed the scope of rebuttal and are excluded from evidence. Employer cannot use the chance for rebuttal as an opportunity to circumvent the 20-day rule in an effort to introduce additional medical opinion on evidence previously submitted in compliance with the 20-day rule. Moreover, any reference to evidence previously submitted in compliance with the 20-day rule is unduly repetitious and should be excluded on that basis as well.

demonstrated a significant response to bronchodilators and retained only a mild pulmonary functional impairment after use of bronchodilators. He opined Claimant retained the capacity to perform his previous job in the coal mines with proper bronchodilator therapy. Dr. Crisalli added that though Claimant did have a mild degree of respiratory impairment, none of this impairment was related to pneumoconiosis or coal dust exposure in the work place. He opined Claimant's impairment was due to emphysema which was secondary to Claimant's cigarette smoking history and asthma. Dr. Crisallli stated neither the emphysema nor asthma were related to, or secondary to, Claimant's coal mine dust exposure. He added his opinion regarding the cause of respiratory impairment and degree of impairment would not change even if Claimant were found to have simple CWP since it was Claimant's asthma and tobacco smoke related emphysema which were the cause of Claimant's respiratory impairment.

Dr. Samuel V. Spagnolo

The medical report of Dr. Spagnolo is dated May 26, 2002 and appears at EX 3. Dr. Spagnolo is Board-Certified in Internal Medicine and Pulmonary Disease. Dr. Spagnolo conducted a comprehensive medical record review and concluded that although Claimant had sufficient exposure history to coal dust, it was his opinion Claimant did not have consistent physical findings or laboratory evidence of any chronic disease of the lung arising from his coal mine employment. He based his opinion on the negative physical examinations of Drs. Rasmussen and Crisalli, the pattern of chest radiographic findings over a seven year period (1988 – 1995), and the valid tests of lung function and exercise capacity between 1988 and 1995. He discussed the pulmonary function test from 1988, 1994 and 1995. He opined that the totality of these findings in conjunction with Claimant's medical history, physical examinations, and chest radiographs were most consistent with the effects of long-term (>20 years of daily) smoking. Dr. Spagnolo noted the lung function studies from 1994 and 1995 did not demonstrate a totally disabling respiratory condition. He concluded from a respiratory standpoint that Claimant was not totally and permanently disabled and would be able to perform his last coal mine work. Dr. Spagnolo reviewed the chest x-ray interpretations and placed great confidence in the "thoughtful and well-reasoned" interpretations of Drs. Wheeler, Wiot, Spitz, Shipley, and Fishman. These physicians confirmed that the radiographic abnormalities were not those of simple or complicated CWP and they have proposed other medical conditions as more likely responsible for the abnormalities. Dr. Spagnolo then concluded there was not sufficient evidence to justify a diagnosis of simple or complicated CWP in this case. In summary, Dr. Spagnolo stated Claimant did not have a chronic restrictive or obstructive impairment arising out of coal mine employment and further did not have any chronic disease of the lung arising from his coal mine employment. Further, he added Claimant's lung condition had not been aggravated by the inhalation of coal dust or CWP.

The supplemental medical report of Dr. Spagnolo is dated October 1, 2002 and appears at EX 5. Dr. Spagnolo reviewed the medical reports of Drs. Rosenberg (May 14,

2002), Crisalli (May 20, 2002), the supplemental report of Dr. Cohen (September 19, 2002), pulmonary function testing of June 18, 2002, and the Occupational Pneumoconiosis Board Findings. In addition, Dr. Rosenberg reviewed various interpretations of the May 9, 1973, May 18, 2001, March 7, 2000, April 12, 1999, and June 18, 2002 chest x-rays.[13] Dr. Spagnolo concluded "none of the newly received supplemental information provides any objective evidence for me to change my earlier opinion in this case." He added the information provided by Dr. Cohen did not provide direct evidence that Claimant's airflow obstruction was caused by his coal mine employment. He again concluded Claimant did not have a chronic pulmonary/respiratory impairment attributable to pneumoconiosis or related to his prior coal mine employment. None of his symptoms, medical complaints or medical conditions was related to Claimant's coal dust exposure or coal mine employment. He added that if it were determined that Claimant had pneumoconiosis, his opinion with regard to his current impairment would remain unchanged.

Occupational Pneumoconiosis Board

The Occupational Pneumoconiosis Board issued a decision on June 18, 2002 and this report appears at CX 1. Drs. Walker, Henry, and Hayes made up the three-member Board. Dr. Walker is a Thoracic Surgeon but is also the Director of Tuberculosis Control for the West Virginia Department of Health. (CX 1). Dr. Hayes is a Board-Certified Radiologist and B-reader. (CX 1). Dr. Henry is Board-Certified in Internal Medicine. (CX 2). The Board found sufficient evidence to justify a diagnosis of occupational pneumoconiosis with 25% pulmonary function impairment attributable to this disease. The Board's findings were based on a physical examination by members of the Board, pulmonary functions study made for the Board, and x-rays of the chest made by a member of the Board. The Board noted a history of shortness of breath and wheezing for 15 years. It was noted that Claimant used bronchodilator medications/inhaler. Claimant denied any chronic productive cough, hemoptysis, asthma, pleurisy, pneumonia, emphysema, tuberculosis, heart disease, pulmonary surgery, hypertension, diabetes or serious injury. The Board found significant findings due to vent studies and clinical findings. The Board also noted chest views showed parenchymal changes consistent with

[13] As noted earlier, this report was admitted as rebuttal evidence to the late filing of Claimant's exhibit 4 that contained the September 19, 2002 supplemental report of Dr. Cohen and x-ray readings from March 7, 2000, April 12, 1999, and May 18, 2001. Those portions of this opinion that are not directly responsive to Claimant's exhibit 4 exceed the scope of rebuttal and are excluded from evidence. Employer cannot use the chance for rebuttal as an opportunity to circumvent the 20-day rule in an effort to introduce additional medical opinion on evidence previously submitted in compliance with the 20-day rule. Moreover, any reference to evidence previously submitted in compliance with the 20-day rule is unduly repetitious and should be excluded on that basis as well.

occupational pneumoconiosis. There was also flattening of the hemidiaphragms compatible with emphysema.

Conclusions of Law

Length of Coal Mine Employment

The parties have stipulated and I find that the miner was a coal miner within the meaning of the Act for at least 39 years. (TR 17-18).

Date of Filing

The parties have stipulated and I find that Claimant filed his claim for benefits under the Act on March 25, 1993. (DX-1; TR 17-18).

Responsible Operator

The parties have stipulated and I find that Westmoreland Coal Company is the responsible operator and will provide payment of any benefits awarded to Claimant. (TR 17-18).

Dependents

The parties stipulated and I find that Claimant has one dependent for purposes of augmentation of benefits under the Act, his wife, Eva Irene. (TR 17-18).

Applicable Regulations

Claimant's claim for benefits was filed on March 25, 1993 and is governed by the Part 718 Regulations. However, on January 19, 2001, substantial changes to Parts 725 and 718 of the Federal Regulations became effective. Based upon my review of the new Regulations, there are two sections that specifically deal with the question of whether these new Regulations are applicable to cases that are currently pending at the time of the enactment.

Pursuant to § 725.2(c) the revisions of this part [Part 725] shall also apply to the adjudication of claims that were pending on January 19, 2001, except for the following sections: § 725.309, 725.310, etc. (see the C.F.R. for the complete list of exempted sections). Accordingly, with the exception of those sections listed as an exemption, the revisions to Part 725 will apply to the facts of this decision.

Pursuant to § 718.101(b) the standards for the administration of clinical tests and examinations contained in subpart B "shall apply to all evidence developed by any party after January 19, 2001 in connection with a claim governed by this part [718]..."

(emphasis added). Accordingly, since the evidence in the instant matter was developed prior to January 19, 2001, the newly enacted § 718, subpart B does not apply.

On August 9, 2001, U.S. District Court Judge Emmet Sullivan upheld the validity of the new Regulations in *National Mining Association v. Chao*, No. 00-3086 (D.D.C. Aug. 9, 2001). However, on June 14, 2002, the United States Court of Appeals for the District of Columbia Circuit ("the court") affirmed in part, reversed in part, and remanded the case. *See National Mining Association v. Department of Labor*, No. 01-5278 (June 14, 2002). Accordingly, I will apply the sections of the newly revised version of Part 718 (i.e. subparts A, C and D) and 725 that took effect on January 19, 2001 that the court did not find impermissibly retroactive to the facts of the instant matter.

Modification

Section 22 of the Longshore and Harbor Workers' Compensation Act provides in part that:

> Upon his own initiative, or upon the application of any party … on the ground of a change in conditions or because of a mistake in a determination of fact … the [fact-finder] may, at any time … prior to one year after the rejection of a claim, review a compensation case …

33 U.S.C. § 922, as incorporated by 30 U.S.C. § 932(a) and implemented by 20 C.F.R. § 725.310.

Section 22 provides the sole avenue for changing otherwise final decisions on a claim. *Metropolitan Stevedore Co. v. Rambo*, 515 U.S. 291, 295 (1995)(*Rambo I*); *Kinlaw v. Stevens Shipping and Terminal Co.*, 33 BRBS 68 (1999), *aff'd.*, No. 99-1954, 2000 U.S.App. LEXIS 31354 (4th Cir. April 5, 2000).

Judicial authority requires a broad reading of Section 22, and neither the wording of the statute nor its legislative history supports a "narrowly technical and impractical construction." *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 255 (1971); *Branham v. BethEnergy Mines, Inc.*, 20 BLR 1-27, 1-31-33 (1996). Given its liberal application, it is clear that the petition seeking modification need not allege any specific ground or relief. *See Keating v. Director, OWCP*, 71 F.3d 1118, 1123, 20 BLR 2-53 (3d Cir. 1995); *Jessee v. Director, OWCP*, 5 F.3d 723, 18 BLR 2-26 (4th Cir. 1993); *accord Consolidation Coal Co. v. Worrell*, 27 F.3d 227, 18 BLR 2-290 (6th Cir. 1994); *see generally Fireman's Fund Insurance Co. v. Bergeron*, 493 F.2d 545, 547 (5th Cir. 1974); H.Rep.No. 1244, 73d Cong., 2d Sess. 4 (1934).

While the modification procedure, and the adjudicator's authority to reopen the claim, is "easily invoked," *Betty B Coal Co. v. Director, OWCP*, 194 F.3d 491, 497, 22 BLR 2-1 (4th Cir. 1999) (*Stanley*), the decision whether to grant modification on the basis

of a mistake in determination of fact is committed to the adjudicator's discretion. *See Kinlaw*, 2000 U.S.App. LEXIS 31354 at *8-10, *aff'g* 33 BRBS 68 (1999); *see also Duran v. Interport Maintenance Co.*, 27 BRBS 8,14 (1993) (Board reviews Section 22 findings under abuse of discretion standard). This is not to say that an administrative law judge or district director may simply deny a petition for modification on a whim. To do so would constitute an abuse of discretion as being arbitrary and capricious and unwarranted by the record.

The adjudicator must examine the record as a whole, *see Keating*, 71 F.3d at 1123, 20 BLR 2-53, render findings which must be supported by substantial evidence, and articulate a rationale for its decision, even though the decision on whether to reopen a claim is committed to its discretion. Indeed, the adjudicator "has the authority, *if not the duty*, to reconsider all the evidence for any mistake of fact or change in condition," *Worrell*, 27 F.3d at 230, 18 BLR 2-290 (emphasis added); *see Jessee*, 5 F.3d at 726, 18 BLR 2-26 (deputy commissioner "must" review request for modification), by examining "wholly new evidence, cumulative evidence, or merely [by] further reflection on the evidence initially submitted." Moreover, if the evidence establishes that a claimant's condition has worsened, modification will be appropriate because a claimant "should receive his benefits if and when he becomes entitled to them." *Stanley*, 194 F.3d at 500 n.4, 22 BLR 2-1.

In every instance, the party who seeks to reopen a claim on modification bears the burden of proof. *Metropolitan Stevedore Co. v. Rambo*, 521 U.S. 121, 138-39 (1997) (*Rambo II*); *Greenwich Collieries v. Director, OWCP*, 990 F.2d 730, 736, 17 BLR 2-64 (3d Cir. 1993), *aff'd* 512 U.S. 267 (1994).

With this in mind, I turn to the merits of Claimant's Request for Modification. While this decision is based on a *de novo* review and consideration of the administrative record as a whole, not all of the evidence that has been introduced prior to the instant request for modification, and has been set forth in the prior Decisions, may again be listed except as required for an analysis of the current request for modification. *See generally Wheeler v. Apfel*, 224 F.3d 891, 895 n.3 (8th Cir. 2000).

Standard of Review

The administrative law judge need not accept the opinion of any particular medical witness or expert, but must weigh all the evidence and draw his/her own conclusions and inferences. *Lafferty v. Cannelton Industries, Inc.*, 12 BLR 1-190 (1989); *Stark v. Director, OWCP*, 9 BLR 1-36 (1986); *Todd Shipyards Corp. v. Donovan*, 300 F.2d 741 (5th Cir. 1962). The adjudicator's function is to resolve the conflicts in the medical evidence; those findings will not be disturbed on appeal if supported by substantial evidence. *Lafferty, supra; Fagg v. Amax Coal Co.*, 12 BLR 1-77 (1988), *aff'd*, 865 F.2d 916 (7th Cir. 1989); *Short v. Westmoreland Coal Co.*, 10 BLR 1-127 (1987); *Piccin v.*

Director, OWCP, 6 BLR 1-616 (1983). *Peabody Coal Co. v. Lowis*, 708 F.2d 266, 5 BLR 2-84 (7th Cir. 1983).

In considering the medical evidence of record, an administrative law judge must not selectively analyze the evidence. *See Wright v. Director, OWCP*, 7 BLR 1-475 (1984); *Hess v. Clinchfield Coal Co.*, 7 BLR 1-295 (1984); *Crider v. Dean Jones Coal Co.*, 6 BLR 1-606 (1983); *Peabody Coal Co. v. Lowis*, 708 F.2d 266, 5 BLR 2-84 (7th Cir. 1983); *see* also *Stevenson v. Windsor Power House Coal Co.*, 6 BLR 1-1315 (1984). The weight of the evidence, and determinations concerning credibility of medical experts and witnesses, however, is for the administrative law judge. *Mabe v. Bishop Coal Co.*, 9 BLR 1-67 (1986); *Brown v. Director, OWCP*, 7 BLR 1-730 (1985); *see also Roberts v. Bethlehem Mines Corp.*, 8 BLR 1-211 (1985); *Henning v. Peabody Coal Co.*, 7 BLR 1-753 (1985); *Peabody Coal Co. v. Benefits Review Board*, 560 F.2d 797, 1 BLR 2-133 (7th Cir. 1977).

As the trier-of-fact, the administrative law judge has broad discretion to assess the evidence of record and determine whether a party has met its burden of proof. *Kuchwara v. Director, OWCP*, 7 BLR 1-167 (1984). In considering the evidence on any particular issue, the administrative law judge must be cognizant of which party bears the burden of proof. Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. *See White v. Director, OWCP*, 6 BLR 1-368 (1983)

Entitlement: In General

To establish entitlement to benefits, a claimant must show that he had pneumoconiosis, that his pneumoconiosis arose out of coal mine employment, that claimant was totally disabled, and that his total disability was due to pneumoconiosis.

The Existence of Pneumoconiosis

30 U.S.C. § 902(b) and 20 C.F.R. § 718.201 define pneumoconiosis as a "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment."[14] The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis.[15] 20 C.F.R. § 718.201. The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."

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[14] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director,* 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1364; *LaBelle Processing Co. v. Swarrow,* 72 F.3d 308 (3d Cir. 1995) at 314-315.

[15] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

(Emphasis added).

" . . . [T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) citing, *Rose v. Clinchfield Coal Co.*, 614 F. 2d 936, 938 (4th Cir. 1980). Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); Tokarcik v. Consolidation Coal Co., 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995).

The claimant has the burden of proving the existence of pneumoconiosis by any one of four methods. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebutable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion. 20 C.F.R. § 718.202(a). Pulmonary function studies are not diagnostic of the presence or absence of pneumoconiosis. *Burke v. Director, OWCP*, 3 B.L.R. 1-410 (1981).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, *i.e.* x-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

Chest X-ray Evidence

A finding of the existence of pneumoconiosis may be made with positive chest x-ray evidence. 20 C.F.R. § 718.202(a)(1). The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). Where two or more x-ray reports are in conflict, the radiologic qualifications of the physicians interpreting the x-rays must be considered. § 718.201(a)(1).

A judge is not required to defer to the numerical superiority of x-ray evidence, although it is within his or her discretion to do so. *Wilt v. Woverine Mining Co.*, 14 B.L.R. 1-70 (1990) *citing Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). The ALJ must rely on the evidence which he deems to be most probative, even where it is contrary to the numerical majority. *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1984).

In addition, the Fourth Circuit noted that pneumoconiosis is "progressive and irreversible" such that it is proper to accord greater weight to later positive x-ray studies over earlier negative studies. It stated further that generally, "later evidence is more likely to show the miner's current condition" where it is consistent in demonstrating a worsening of the miner's condition. *Lane Hollow Coal Co. v. Director, OWCP [Lockhart]*, 137 F.3d 799 (4th Cir. 1998).

I agree with Judge Leland's conclusion that the preponderance of the previously submitted x-ray evidence (prior to March 1999) was negative for coal worker's pneumoconiosis. I further agree and find that eight (8) dually-qualified Board Certified Radiologists and B-readers found no radiographic evidence of pneumoconiosis while only two (2) dually-qualified physicians diagnosed the presence of pneumoconiosis.

However, in this most recent request for modification several new x-rays have been submitted into evidence. Of the newly submitted evidence, there are forty-six (46) interpretations of four (4) x-rays (April 12, 1999, March 7, 2000, May 18, 2001, and June 18, 2002) in the record. The Board has held that it is proper to credit the interpretation of a dually-qualified physician over the interpretation of a B-reader. *Cranor v. Peabody Coal Co.*, 22 BLR 1-1 (1999). (en banc on recon.). Of the forty-six newly submitted interpretations, there were twelve (12) positive interpretations by dually-qualified Board-Certified Radiologists and B-readers while there were twenty-three (23) negative interpretations by dually-qualified Board-Certified Radiologists and B-readers. Accordingly, as the vast majority of dually-qualified interpretations remain negative for pneumoconiosis, I find that Claimant has failed to establish, by the preponderance of the evidence, the existence of pneumoconiosis pursuant to § 718.202(a)(1).

Biopsy Evidence

A biopsy may be the basis for a finding of the existence of pneumoconiosis. § 718.202(a)(2). A finding in a biopsy of anthracotic pigmentation, however, shall not be sufficient, by itself, to establish the existence of pneumoconiosis. § 718.202(a)(2).

In the instant matter, there is no biopsy evidence. Accordingly, I find that Claimant has failed to establish the presence of pneumoconiosis, by the preponderance of the evidence, pursuant to § 718.202(a)(2).

The Presumptions

If the presumptions described in §§ 718.304, 718.305 or 718.306 are applicable, it shall be presumed that the miner is or was suffering from pneumoconiosis. § 718.202(a)(3). Although Drs. Pathak, Miller, Cappiello, and Ahmed identified the presence of large opacities, I find that the overwhelming majority of the most expert x-ray interpreters did not find any large opacities. Accordingly, I find that the x-rays do not invoke the irrebuttable presumption in § 718.304.

Therefore, since none of the foregoing presumptions are applicable in this matter, I find that Claimant has failed to establish the presence of pneumoconiosis pursuant to § 718.202(a)(3).

Medical Opinion Evidence

Additionally, a determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data and medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative x-ray. 20 C.F.R. § 718.202(a). Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contraindicates it. *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

In the instant matter, the reports of twelve (12) physicians and the findings of the Occupational Pneumoconiosis Board were submitted regarding the miner's medical condition. In general, Drs. Chillag, Loudon, Fino, Castle, Rosenberg, Crisalli, and Spagnolo found no evidence of pneumoconiosis. While Drs. Treharne, Ranavaya, Rasmussen, and Cohen and the Occupational Pneumoconiosis Board concluded that the miner had coal workers pneumoconiosis. Dr. Ottoviano reported Claimant had a history of pneumoconiosis but did not diagnose this condition. (DX 27). Because Dr. Ottoviano did not make any independent assessment as to whether Claimant had or did not have pneumoconiosis, I accord his opinion less weight on this issue.

I accord greater weight to the highly qualified opinion of Dr. Cohen. I find that Dr. Cohen's reports are well-documented. *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987). Dr. Cohen clearly sets forth, in a point-by-point manner, his reasons for concluding Claimant had coal worker's pneumoconiosis. Moreover, Dr. Cohen properly took into consideration Claimant's significant history of approximately 43 years of

underground coal mine employment that ended in 1993 and Claimant's 24 to 25 pack year history of cigarette smoking that ended in 1976. *Hoffman v. B&G Construction Co.*, 8 BLR 1-65 (1985). I also find that the opinion of Dr. Cohen is well-reasoned. *Fields, supra*. I find the underlying documentation contained within his reports is adequate to support the conclusion of Dr. Cohen that the miner had coal worker's pneumoconiosis. Dr. Cohen noted the disparity in the interpretation of the chest x-rays and stated he could not make a clear determination of the presence or absence of pneumoconiosis from the chest x-ray reports. However, Dr. Cohen noted Claimant had a moderate, partially reversible obstructive ventilatory impairment. He identified two risk factors for the respiratory insufficiency: the Claimant's significant history of underground coal mine employment (legal pneumoconiosis) and his modest smoking history. Dr. Cohen did not try to minimize Claimant's remote smoking history as a contributing factor in his respiratory ailments but did indicate that coal mine dust exposure does cause many of the same findings as smoking (i.e. obstructive defect) and that it was not possible to exclude coal mine dust exposure as at least one factor in Claimant's development of COPD (legal pneumoconiosis). For these reasons, I accord more weight to the opinion of Dr. Cohen.

I find that the conclusions of Dr. Cohen are supported by the opinion of Dr. Rasmussen who also noted the connection, in general, between coal mine dust exposure and the development of obstructive pulmonary disease. (DX 82). Nevertheless, I accord less weight, overall, to the opinion of Dr. Rasmussen because he failed to specifically identify what factors he considered in attributing Claimant's COPD, at least in part, to his coal mine dust exposure.

I accord less weight to the opinion of Dr. Treharne who noted Claimant's lung disease was "most likely" due to coal dust exposure and cigarette smoking. (DX 65). I find her opinion regarding the existence of pneumoconiosis to be equivocal. I accord less weight to the opinion of Dr. Ranavaya and the Occupational Pneumoconiosis Board because both failed to provide a rationale for finding a nexus between Claimant's pulmonary disease and his coal mine employment. (DX 12; CX 1).

I accord less weight to the opinions of Drs. Chillag, who is Board-Certified in Internal Medicine, and Loudon, who has no board certifications but was educated in Great Britain. Although these physicians have impressive credentials, they are not as highly qualified as Drs. Cohen, Fino, Castle, Rosenberg, Crisalli, and Spagnolo who are all Board-Certified in Internal Medicine and Pulmonary Disease. For this reason, I find the opinions of Drs. Chillag and Loudon to be less probative than the highly qualified opinions of Drs. Cohen, Fino, Castle, Rosenberg, Crisalli, and Spagnolo and accordingly should be given less weight. *Burns v. Director, OWCP*, 7 BLR 1-597 (1984).

I accord less weight to the opinions of Drs. Fino and Castle who diagnosed the presence of asthma and a smoking-related obstructive ventilatory abnormality. I find that the opinions of Drs. Fino and Castle are not well-reasoned inasmuch as they failed to

explain how they were able to completely eliminate Claimant's significant coal mine dust exposure as a possible contributing factor to the noted obstructive defect, in light of the fact that Claimant stopped smoking in or around 1976 but did not stop working in the coal mines until 1993. *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989)(en banc). Moreover, I find that Dr. Cohen, in his report, persuasively addressed many issues raised by Drs. Fino and Castle and effectively countered each point. (DX 97). In addition, it is well settled that coal dust exposure can be related to the development of asthma. *See Robinson v. Director, OWCP*, 3 BLR 1-798.1 (1981). However, Drs. Fino and Castle did not adequately explain how each was able to rule out coal dust exposure as a factor in the formation of Claimant's so-called asthma. For these reasons, I find the opinions of Drs. Fino and Castle are not well-reasoned and as such should be accorded less weight on this issue.

Although Dr. Rosenberg is a highly qualified pulmonologist, I accord less weight to his opinion. Dr. Rosenberg concluded Claimant did not have clinical pneumoconiosis based on the x-ray evidence and CT scan. He noted that the question to be addressed was whether or not severe disabling COPD could occur in an individual absent the complicated form of this illness. He acknowledged coal dust exposure could cause the development of COPD even if a chest x-ray was negative. (EX 2). He then concluded that while coal mine dust could cause COPD, severe disabling COPD did not occur in relationship to coal mine dust exposure absent the presence of complicated CWP. Based on the forgoing reasoning, Dr. Rosenberg opined that Claimant's disabling COPD was not the consequence of coal mine dust exposure (i.e. no legal pneumoconiosis). (EX 2). I find this all or nothing approach by Dr. Rosenberg to be less credible and less persuasive than the well-reasoned report of Dr. Cohen. It is well settled that coal mine dust does not have to be the *sole* cause of the COPD in order for there to be a diagnosis of legal pneumoconiosis. The definition of legal pneumoconiosis includes any chronic lung disease arising out of coal mine employment. § 718.201(a)(2). A disease "arising out of coal mine employment" includes any chronic pulmonary disease significantly related to, or substantially aggravated by dust exposure in the coal mine. § 718.201(a)(3). Therefore, it is inappropriate for Dr. Rosenberg to use the absence of complicated pneumoconiosis as the sole criterion to exclude coal mine dust as a possible factor in causing the miner's severe COPD. Based on the foregoing, I find the opinion of Dr. Rosenberg is not well-reasoned and should be accord less weight.

I accord less weight to the opinion of Dr. Crisalli who found Claimant had demonstrated a significant response to bronchodilators and retained only a mild pulmonary functional impairment after use of bronchodilators. He opined Clamant had emphysema secondary to cigarette smoking and asthma. He maintained Claimant did not have coal worker's pneumoconiosis. Likewise, I accord less weight to the opinion of Dr. Spagnolo who concluded Claimant's medical history, physical examinations, and chest radiographs were most consistent with the effects of long term smoking. He found no evidence of pneumoconiosis. I find that the reports of Drs. Crisalli and Spagnolo are not as well-

reasoned and well-documented as the report of Dr. Cohen. It is well settled that coal dust exposure can be related to the development asthma and emphysema. *See Robinson v. Director, OWCP*, 3 BLR 1-798.1 (1981). However, Dr. Crisalli does not adequately explain how he was able to rule out coal dust exposure as a factor in the formation of either disease. Likewise, Dr. Spagnolo failed to adequately explain how he was able to completely eliminate Claimant's substantial history of coal mine dust exposure as a possible cause of Claimant's pulmonary dysfunction. Moreover, Dr. Spagnolo was careful to state that coal mine dust exposure did not cause any pulmonary dysfunction but did not specifically diagnose any condition responsible for the acknowledged dysfunction apparent on pulmonary function studies. For these reasons, I find the opinions of Drs. Spagnolo and Crisalli are not well-reasoned and as such should be accorded less weight.

In summary, based on the conclusions of the better reasoned opinions, I find that Claimant has established the existence of pneumoconiosis pursuant to § 718.202(a)(4).

Weighing all Evidence Together

Pursuant to the holding in *Compton, supra*, I must weigh all of the evidence under § 718.202(a) together in order to make a determination regarding the existence of pneumoconiosis. I found previously that Claimant was unable to establish the existence of pneumoconiosis through x-ray evidence (clinical pneumoconiosis) pursuant to § 718.202(a)(1). I found that there was no biopsy evidence in the record to establish the existence of pneumoconiosis pursuant to § 718.202(a)(2) and that the presumptions at § 718.202(a)(3) were inapplicable to the facts of the instant matter. In addition, I found that the conclusions of the better reasoned opinions established the existence of pneumoconiosis (legal pneumoconiosis) pursuant to § 718.202(a)(4). Accordingly, weighing all of the foregoing evidence together, I find Claimant has established the existence of pneumoconiosis pursuant to § 718.202(a).

Because Claimant has established an element of entitlement that had not been previously established, I find Claimant has established a material change in conditions pursuant to § 725.310.

Pneumoconiosis Arose Out of Coal Mine Employment

Pursuant to § 718.203(b) if a miner who is suffering or suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment. Employer did not submit any evidence to rebut said presumption. Accordingly, as Claimant worked for more than ten years in a coal mine, I find Claimant has established that the pneumoconiosis arose out of Claimant's coal mine employment pursuant to § 718.203.

Evidence of Total Disability

Total disability is defined as pneumoconiosis which prevents or prevented a miner from performing his usual coal mine employment or other gainful work. §§ 718.305(c), 718.204(b)(1). Section 718.204 sets out the standards for determining total disability. This section provides that in the absence of contrary probative evidence, evidence that meets the quality standards of the subsection shall establish the miner's total disability. In his Decision and Order dated March 30, 1999 (DX 89), Judge Leland found Claimant had established the existence of a total disability pursuant to § 718.204 (c). This finding was affirmed by the Benefits Review Board as unchallenged on appeal. (DX 96).

Although Employer contested this issue at the hearing, they did not specifically challenge this issue in their closing brief.[16]

Disability Causation

The final issue is whether Claimant has established disability causation at Section 718.204(c)(1).

Pursuant to § 718.204(c)(1) a miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis…is a substantially contributing cause of the miner's totally disabling respiratory impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it:

(i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or
(ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

I accord greater weight to the opinion of Dr. Cohen who found the presence of legal pneumoconiosis and concluded that Claimant was totally disabled from performing his last coal mine employment due to a moderate obstructive impairment caused by coal mine dust exposure and cigarette smoking, diffusion impairment, gas exchange abnormality, and emphysema. I find Dr. Cohen's opinion to be well-reasoned and well-documented. I also find his reasoning to be credible and highly persuasive. For these reasons, I accord his opinion great weight.

On the other hand, I find the opinions of Drs. Loudon ("probably" not totally disabled), Castle ("probably" permanently, totally disabled), Treharne, Ranavaya, Ottoviano, and the Occupational Pneumoconiosis Board to be equivocal on the issue of

[16] The most recent pulmonary function study of June 18, 2002 is qualifying under the regulations and adds further support to Judge Leland's conclusion of total disability.

whether a total disability exists and, therefore, each will be accorded less weight on the issue of causation. *Toler v. Eastern Associated Coal Co.*, 43 F.3d 109 (4th Cir. 1995).

I accord less weight to the opinion of Dr. Rosenberg who stated "probably based on the decreased FEV 1% ratios" Claimant would be totally disabled from performing his last coal mine employment. I find his opinion in this regard to be equivocal and therefore accord his opinion less weight.

I accord less weight to the opinion of Dr. Spagnolo who found, contrary to the findings in this opinion and that of Judge Leland, that Claimant was not totally disabled from his last coal mine employment and that Claimant did not suffer from pneumoconiosis. *Toler v. Eastern Associated Coal Co.*, 43 F.3d 109 (4th Cir. 1995). Moreover, I accord less weight to the opinion of Dr. Crisalli who found Claimant would be able to perform his last coal mine employment with proper bronchodilator therapy. I find the underlying assumption of Dr. Crisalli's opinion to be unverified. There is no evidence in the record that shows Claimant would be able to perform his last coal mine employment even if he was given proper treatment. For this reason, I find the opinion of Dr. Crisalli to be unsupported by the evidence of record and, therefore, accord his opinion less weight.

Although Drs. Chillag and Fino concluded Claimant was totally disabled from performing his last coal mine employment, I accord their opinions less weight. Although Dr. Chillag has impressive credentials, he is not as highly qualified as Dr. Cohen, who is Board-Certified in Internal Medicine and Pulmonary Disease. *Burns, supra.* Moreover, Dr. Chillag found no pneumoconiosis to be present contrary to the findings of this opinion. *Toler, supra.* Even though Dr. Chillag noted his opinion regarding the degree and cause of Claimant's pulmonary impairment would not change even if it were determined Claimant did have CWP, I find Dr. Chillag provided no explanation as to why that would be the case. For these reasons, I accord the opinion of Dr. Chillag less weight. Likewise, I accord less weight to the opinion of Dr. Fino on the issue of causation because he maintained no pneumoconiosis was present. *Toler, supra.*

Accordingly, I find Claimant has established, by the preponderance of the better-reasoned evidence, his total disability was due to coal worker's pneumoconiosis pursuant to § 718.204(c).

Conclusion

Because Claimant has established all elements of entitlement, I must conclude that he has established entitlement to benefits under the Act. In a petition for modification, the date from which benefits are payable, in a case where a change in conditions has been established, and where evidence does not establish the month of onset, benefits shall be payable from the month in which the claimant requested modification. 20 C.F.R.

§ 725.303(d) (Dec. 20, 2000). In the instant matter Claimant requested modification on March 21, 2000.

Attorney's Fees

No award of attorney's fees for services to the Claimant is made herein since no application has been received. Thirty days are hereby allowed to Claimant's counsel for the submission of such application. His attention is directed to 20 C.F.R. §§ 725.365 and 725.366 of the regulations. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. Parties have ten days following receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim of ROBERT J. DAMRON for black lung benefits under the Act is hereby GRANTED, and

It is hereby ORDERED that WESTMORELAND COAL COMPANY, the Responsible Operator, shall pay to the Claimant, ROBERT J. DAMRON, all augmented benefits to which he is entitled under the Act, commencing as of March 1, 2000.

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MICHAEL P. LESNIAK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this Decision and Order was filed in the office of the District Director, by filing a notice of appeal with the *Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601*. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.